SERFF Tracking Number:	*AEGB-126762984*	*State:*	*Arkansas*
Filing Company:	*Western Reserve Life Assurance Co. of Ohio*	*State Tracking Number:*	*46492*
Company Tracking Number:	*L121 0510WAR*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*L121 0510WAR*		
Project Name/Number:	*Application For Individual Life Insurance/L121 0510WAR*		

Filing at a Glance

Company: Western Reserve Life Assurance Co. of Ohio

Product Name: L121 0510WAR	SERFF Tr Num: AEGB-126762984	State: Arkansas
TOI: L04I Individual Life - Term	SERFF Status: Closed-Approved-Closed	State Tr Num: 46492
Sub-TOI: L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life	Co Tr Num: L121 0510WAR	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Theresa Meyers	Disposition Date: 08/17/2010
	Date Submitted: 08/13/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Application For Individual Life Insurance
Project Number: L121 0510WAR
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 08/17/2010

Deemer Date:
Submitted By: Theresa Meyers

Filing Description:
August 13, 2010

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 08/17/2010
Created By: Theresa Meyers
Corresponding Filing Tracking Number: 30822730

Commissioner of Insurance
Arkansas Insurance Division
1200 West 3rd Street

SERFF Tracking Number:	*AEGB-126762984*	*State:*	*Arkansas*
Filing Company:	*Western Reserve Life Assurance Co. of Ohio*	*State Tracking Number:*	*46492*
Company Tracking Number:	*L121 0510WAR*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*L121 0510WAR*		
Project Name/Number:	*Application For Individual Life Insurance/L121 0510WAR*		

Little Rock, Arkansas 72201-1904

Re: WESTERN RESERVE LIFE ASSURANCE CO. OF OHIO
NAIC #: 468-91413
FEIN #: 43-1162657
L121 0510WAR – Application for Individual Life Insurance

Dear Sir/Madam:

Please find attached a copy of the above referenced form. This is a new form and is not intended to replace any form previously approved by your Department. This form is being submitted in final printed form in which it will be distributed to Insureds. This form is subject to only minor modifications in paper size and stock, ink, border, Company logo, Company address, adaptation to computer printing, and Officers' signatures.

Life Application – This is an individual life insurance application that will be used with our life portfolio.

This application will be used via paper by licensed agents. We intend to use this form in a traditional manner whereby the Owner/applicant signs the application in ink and submits the application to the Company.

We also plan to make this application form available electronically. It is our intent to use this application form in a variety of electronic environments, including a laptop and web based application process. Regardless of the application process used, we intend to adopt measures to secure both the integrity of the document once signed, and the confidentiality of any information transmitted, including transmission of information via a secured socket layer/secured line. The information contained in the application will be transmitted to our administrative office electronically as well as the electronic signature of the Owner/Applicant. Current technology will be used to ensure that the confidential information is not compromised. All processes used will comply with the Uniform Electronic Transactions act, and to the extent applicable, the Federal ESIGN Act.

We hereby certify that any electronic signature we obtain will be linked to the date on the electronic application in such a manner that the electronic signature is invalidated if any of the data on the application is changed. We also certify that such electronic signature intended for use with this application will not be affixed to or duplicated on any other document.

A copy of the application, identical to the filed form, will be printed and made part of any policy issued.

SERFF Tracking Number:	*AEGB-126762984*	*State:*	*Arkansas*
Filing Company:	*Western Reserve Life Assurance Co. of Ohio*	*State Tracking Number:*	*46492*
Company Tracking Number:	*L121 0510WAR*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*L121 0510WAR*		
Project Name/Number:	*Application For Individual Life Insurance/L121 0510WAR*		

We would appreciate your review and approval of this form. Should you have any questions or need any additional information, please do not hesitate to contact me.

Sincerely,

WESTERN RESERVE LIFE ASSURANCE CO. OF OHIO

Theresa Meyers
Policy Analyst
Contract Development
(319) 355-7520 (collect)
Fax #: (319) 369-2501
thmeyers@aegonusa.com

Company and Contact

Filing Contact Information

Theresa Meyers, Policy Analyst	thmeyers@aegonusa.com
4333 Edgewood Rd. NE	319-355-7520 [Phone]
MS 2225	319-355-2501 [FAX]
Cedar Rapids, IA 52499	

Filing Company Information

Western Reserve Life Assurance Co. of Ohio	CoCode: 91413	State of Domicile: Ohio
4333 Edgewood Road NE	Group Code: 468	Company Type:
Cedar Rapids, IA 52499	Group Name:	State ID Number:
(319) 355-7888 ext. [Phone]	FEIN Number: 43-1162657	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No

SERFF Tracking Number:	*AEGB-126762984*	*State:*	*Arkansas*
Filing Company:	*Western Reserve Life Assurance Co. of Ohio*	*State Tracking Number:*	*46492*
Company Tracking Number:	*L121 0510WAR*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*L121 0510WAR*		
Project Name/Number:	*Application For Individual Life Insurance/L121 0510WAR*		
Fee Explanation:	$50.00 per form X 1 = $50.00		
Per Company:	No		

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Western Reserve Life Assurance Co. of Ohio	$50.00	08/13/2010	38759941

SERFF Tracking Number:	*AEGB-126762984*	*State:*	*Arkansas*
Filing Company:	*Western Reserve Life Assurance Co. of Ohio*	*State Tracking Number:*	*46492*
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TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*L121 0510WAR*		
Project Name/Number:	*Application For Individual Life Insurance/L121 0510WAR*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/17/2010	08/17/2010

SERFF Tracking Number:	*AEGB-126762984*	*State:*	*Arkansas*
Filing Company:	*Western Reserve Life Assurance Co. of Ohio*	*State Tracking Number:*	*46492*
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Project Name/Number:	*Application For Individual Life Insurance/L121 0510WAR*		

Disposition

Disposition Date: 08/17/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AEGB-126762984*	*State:*	*Arkansas*
Filing Company:	*Western Reserve Life Assurance Co. of Ohio*	*State Tracking Number:*	*46492*
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Product Name:	*L121 0510WAR*		
Project Name/Number:	*Application For Individual Life Insurance/L121 0510WAR*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Statement of Variability		Yes
Form	Application For Individual Life Insurance		Yes

SERFF Tracking Number:	*AEGB-126762984*	*State:*	*Arkansas*
Filing Company:	*Western Reserve Life Assurance Co. of Ohio*	*State Tracking Number:*	*46492*
Company Tracking Number:	*L121 0510WAR*		
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Product Name:	*L121 0510WAR*		
Project Name/Number:	*Application For Individual Life Insurance/L121 0510WAR*		

Form Schedule

Lead Form Number: L121 0510WAR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	L121 0510WAR	Application/ Enrollment Form	Application For Individual Life Insurance	Initial		51.300	L121 0510WAR.pdf

Western Reserve Life Assurance Co. of Ohio **APPLICATION FOR INDIVIDUAL LIFE INSURANCE** [ ]

Home Office, [4333 Edgewood Road NE, Cedar Rapids, IA 52499]

PROPOSED INSURED INFORMATION

Name *(First, M.I., Last)*			Mailing Address (Cannot be a P.O. Box)	
Home Telephone No. ( )	Work Telephone No. ( )	Birth Date	Age	Birth Place *(State or Country)*
Height / Weight	Marital Status	Sex	U.S. Citizen ☐ Yes ☐ No	*If no, give immigration status/type of visa:*
Occupation & Duties	Annual Income Current Year_____ Annual Income Previous Year_____ Net Worth _____		Social Security No. or Tax I.D. No. Drivers License No./ State	

Have you used any tobacco within the last 5 years? ☐ Yes ☐ No If yes, list type and when used last_____

BENEFICIARY AND RELATIONSHIP TO PROPOSED INSURED *(Unless otherwise noted, the beneficiary of other persons proposed for Coverage will be the proposed Insured.)*

Primary	Relationship	Primary	Relationship
Primary	Relationship	Contingent	Relationship

OWNER(S) *(Unless otherwise noted, the Owner will be the Insured.)*

Name	Relationship to proposed Insured	Social Security Number
Address (Cannot be a P.O. Box)	Birth Date	Phone ( )

Are you a citizen of ☐ USA ☐ Other Country_____ ☐ Type of VISA _____

POLICY INFORMATION

Plan: _____ ☐ Level ☐ Increasing Guarantee Period_____	Amount of Insurance $	Planned Premium $

Mode of Payment (for bank draft, complete authorization, and initial payment required.)
☐ Monthly Bank Draft ☐ Quarterly ☐ Semi-Annual ☐ Annual

SECONDARY ADDRESSEE *(A secondary addressee may be named who will receive notice of a possible lapse in coverage.)*

Name (First, M.I., Last)	Address, City, State, Zip Code (Cannot be a P.O. Box)

ADDITIONAL BENEFITS *(Availability Varies)*

	Benefit Units Monthly $ Amount		Benefit Units Monthly $ Amount
☐ Monthly Disability Income Rider		☐ Critical Illness Accelerated Death Benefit Rider	
☐ Waiver of Premium Benefit Rider		☐ ROP	
☐ Children's Benefit Rider		☐ Other_____	
☐ Additional Insured Rider (AIR)		☐ Other_____	

Name of Other Proposed Insured(s)	Birth Date	Sex	Height	Weight	Social Security Number	Relationship to Insured	Amount of Insurance	Used Tobacco in last 5 years? If yes, list type and when used last
								❑ Yes ❑ No
								❑ Yes ❑ No
								❑ Yes ❑ No

LIFE INSURANCE IN FORCE *If none check this box.* ☐

Insured's Name	Company/ Policy Number	Face Amount
		$
		$
		$
		$
		$
		$

DISABILITY INCOME - INSURANCE IN FORCE *If none check this box.* ☐ *Complete only if applying for Disability Rider.*

Insured's Name	Company	Policy Number	Monthly Amount	Benefit Period	Elimination Period

PERSONAL PHYSICIAN(S)

Name of Proposed Insured	Personal Physician(s) Name, Address, Phone Number	Date Last Visited, Reason, Result

GENERAL QUESTIONS Complete the following. *For YES answers, give full details in the space provided on the next page.*

1. Do you have any existing life insurance or annuity contracts with the Company or any other company? ❑ Yes ❑ No
   a. Will the insurance applied for replace or change any life insurance or annuity contract in force with the Company or any other company? (If yes, submit the state required forms.) ❑ Yes ❑ No

Have you or any proposed Insured,

2. Is there an application for life, accident or sickness insurance now pending or contemplated on the proposed Insured with the Company or any other company? If Yes, give details. ❑ Yes ❑ No
3. Been declined or offered a rated or modified life or health policy? ❑ Yes ❑ No
4. Within the past 5 years,
   a. Plead guilty to or been convicted of a moving violation, including DUI, or had a driver's license suspended or revoked? (If yes, provide state and driver's license number.) ❑ Yes ❑ No
   b. Been or is now fully or partially disabled? ❑ Yes ❑ No
   c. Plead guilty to or been convicted of any felony or misdemeanor? Do you have such a charge currently pending against you? ❑ Yes ❑ No
5. Within the past 2 years,
   a. Taken part in any type of racing, mountain climbing, underwater or sky diving, hang gliding or plan to within the next 2 years? ❑ Yes ❑ No
   b. Flown other than a fare paying passenger on a scheduled airline, or plan to within the next 2 years? (If yes, complete the Aviation and Avocation Questionnaire.) ❑ Yes ❑ No
   c. Lived outside of the United States or plan to live outside of the United States within the next 2 years? ❑ Yes ❑ No
   d. Traveled outside of the United States or intend to within the next 2 years? ❑ Yes ❑ No
6. Within the past 10 years, used drugs (such as: hallucinogens, barbiturates, excitants or narcotics) except as medication prescribed by a physician, or been treated or counseled for drug or alcohol use? ❑ Yes ❑ No
7. Family History: Is there a history of cardiovascular disease (including coronary artery disease, stroke or transient ischemic attack), internal cancer, or melanoma in parents/ siblings prior to age 60? If yes, please provide details including, type of cancer (if applicable) and if there was a death due to this condition. ❑ Yes ❑ No
8. Within the past two years consumed six or more alcoholic beverages per week? ❑ Yes ❑ No
9. Had any weight change of 10 or more pounds in the past year? ❑ Yes ❑ No

MEDICAL QUESTIONS Each question must be individually asked and answered. *For YES answers, give full details in the space provided below.*

1. Have you or any proposed Insured EVER tested positive or been diagnosed by a member of the medical profession for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? ❑ Yes ❑ No

Within the past 10 years, have you or any proposed Additional Insured (including any children applying) been treated or diagnosed by a health care professional as having any disease or disorder of the:

2. Blood or circulatory system (such as: heart attack, heart disease, palpitations, heart murmur, or chest pain, high blood pressure, stroke, anemia)? ❑ Yes ❑ No
3. Respiratory system (such as: emphysema, asthma, shortness of breath, chronic cough or sleep apnea)? ❑ Yes ❑ No
4. Brain or nervous system (such as seizures, epilepsy, multiple sclerosis, mental illness, depression, suicide attempt, eating disorder, dementia or Alzheimer's disease)? ❑ Yes ❑ No
5. Sugar, albumin, or blood in urine, or other illness or disease of the kidneys, bladder, or urinary system, prostate, breast, sexually transmitted disease or any other reproductive disorder? ❑ Yes ❑ No
6. Stomach, intestine, liver (such as: ulcer, colitis, Crohn's disease or hepatitis)? ❑ Yes ❑ No
7. Endrocrine system, muscles or bone (such as diabetes, thyroid, lupus, arthritis, or back problems)? ❑ Yes ❑ No
8. Cancer, tumor, polyps, melanoma or other malignancy? ❑ Yes ❑ No
9. Had or been advised to have a check-up, consultation, lab test, EKG, X-ray or other diagnostic test except as those related to the Human Immunodeficiency Virus (AIDS virus)? ❑ Yes ❑ No
10. Are you currently under the observation of a physician or taking medication? ❑ Yes ❑ No

ADDITIONAL INFORMATION *Explain all "yes" answers below.*

Question Number	Name of Proposed Insured	Details to General and Medical Questions (Diagnosis, Dates, Durations) Medical Facilities & Physicians Names, Addresses, Phone Numbers

ILLUSTRATION CERTIFICATION (Universal Life only) The box below MUST be checked if a signed illustration of the policy applied for is NOT enclosed with this application.

☐ The Applicant/Owner and the Licensed Agent certify that they have each read and agree with their respective statements below regarding the policy applied for:

Applicant's/Owner's statement: By signing this application, I, the Applicant/Owner acknowledge that I have NOT received an illustration of the policy applied for and understand that an illustration of the policy as issued will be provided no later than the policy delivery date. **Licensed Agent's statement:** By signing this application, I, the Licensed Agent certify that I have NOT provided an illustration of the policy as applied for. However, I will provide an illustration conforming to the policy as issued upon or prior to delivery of the policy.

ACKNOWLEDGMENT OF PROPOSED OWNER AND INSURED(S) – Each of the undersigned hereby certifies and represents as follows: I have read the application and all statements and answers as they pertain to me. The statements and answers given on this application are true and complete to the best of my knowledge and belief. I acknowledge and agree (A) that the statements and answers in this application and any amendments shall be the basis for any insurance issued by the Company and no information about me will be considered to have been given to the Company unless stated in the application; (B) that the agent does not have the authority to waive any question on this application, to decide if insurance will be issued, or to modify any term or provision of any insurance which may be issued based on this application, only a writing signed by an officer of the Company can change the terms of this application or the terms of any insurance issued by the Company; (C) except as provided in the Conditional Receipt, if issued with the same proposed Insured(s) as on this application, no policy applied for shall take effect until after all of the following conditions have been met: 1) the minimum initial premium must be received by the Company; 2) the proposed Owner must have personally received and accepted the policy during the lifetime of all proposed Insured(s) and while all proposed Insured(s) are in good health; and 3) on the date of the later of either 1) or 2) above, all of the statements and answers given in this application must be true and complete to the best of my knowledge and belief, and the insurance will not take effect if the facts have changed. Unless otherwise stated the undersigned applicant is the premium payor and Owner of the policy applied for.

I authorize MIB Group, Inc. and its members or affiliates, my employer or former employer, any consumer reporting agency or governmental agency, medical provider, or any insurer or reinsurer to provide medical or personal information about me that is reasonably required for the purposes stated in this authorization to Western Reserve Life Assurance Co. of Ohio, its administrators, representatives or its reinsurers. I understand the information obtained by use of the authorization will be used by Western Reserve Life Assurance Co. of Ohio to determine eligibility for insurance, and eligibility for benefits under an existing policy. Any information obtained will not be released by Western Reserve Life Assurance Co. of Ohio to any person or organization except to reinsurers, MIB Group, Inc. and its members or affiliates, or other persons or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may authorize. This authorization will expire 30 months from the date signed. A copy of this authorization shall be as valid as the original. Either my authorized representative or I may receive a copy of this authorization upon request.

The Company shall have sixty days from the date hereof within which to consider and act on this application and if within such period a policy has not been received by the applicant or if notice of approval or rejection has not been given, then this application shall be deemed to have been declined by the Company.

I acknowledge receipt of the (1) Notice to Persons Applying for Insurance Regarding Investigative Report, (2) MIB Group, Inc. Pre-Notification, (3) Notice of Insurance Information Practices, and (4) Disclosure for Accelerated Terminal Illness Benefit, if required. I understand that any omissions or misstatements in this application could cause an otherwise valid claim to be denied under any insurance issued from this application.

I also understand that I will not receive any insurance coverage for any money paid with this application unless a policy is issued except in accordance with the terms of the Conditional Receipt.

FRAUD WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Please make checks payable to Western Reserve Life Assurance Co. of Ohio. Do not make checks payable to the agent or leave the payee space blank on your check.

Amount paid with application: $ _____ **Best time for a personal history interview:** _____ **a.m. / p.m. Okay to contact at work?** ☐ **Yes** ☐ **No**

Dated at _____ this _____ day of _____ , _____
City State Month Year

_____ _____
Signature of proposed Insured (if age 15 or over) Signature of proposed Owner (if other than proposed Insured)

_____ _____
Signature of Parent or Legal Guardian (if proposed Insured is not of age of majority as required by the state where the Policy is issued for delivery and Parent/Guardian has not signed as Owner) Signature of Additional Insured

TAX NOTICE AND TAXPAYER IDENTIFICATION NUMBER CERTIFICATION

Under current federal tax laws, the Company is required to obtain your Taxpayer Identification Number (e.g., a social security or employer identification number, or "TIN") and certification that you are not subject to backup withholding. Please review the following certification and sign accordingly.

Under penalties of perjury, I certify that (1) the TIN listed in this application is my correct TIN; (2) I have not been notified that I am subject to backup withholding or I am not subject to backup withholding because I am an exempt recipient; and (3) I am a U.S. Person (U.S. citizen/legal resident). If not a U.S. Person, I have completed the appropriate Form W-8BEN. The IRS does not require your consent to any provision of this form other than this certification.

Signature of proposed Owner _____ **Date** _____

AGENT INFORMATION & SIGNATURE

Signature of Agent	(Print First and Last Name)	Agent #
( )	( )	
Telephone Number	Agent Fax #	Agent E-mail Address
Split Agent Signature (If Applicable)	(Print First and Last Name)	Agent #
( )	( )	
Telephone Number	Agent Fax #	Agent E-mail Address

- Did you ask all questions on the application in the presence of all proposed Insureds, record the answers as given, and witness all signatures? ☐ Yes ☐ No If not, please provide details. _____
- Do you have any knowledge or reason to believe that the proposed Insured has existing life insurance or annuity contracts with the Company or any other company? ☐ Yes ☐ No
- Do you have any knowledge or reason to believe that the insurance applied for will replace or change any existing life insurance or annuity contracts? ☐ Yes ☐ No (If yes, submit the state required forms.)

CONDITIONAL RECEIPT

(Detach and leave with applicant only if money is submitted with application. **If within the past 12 months any proposed Insured has been treated for or been diagnosed by a member of the medical profession for heart trouble, stroke or cancer, no payment may be accepted with the application.** Do not accept money unless all required signatures below are obtained.)

PLEASE READ THIS CAREFULLY

No coverage will become effective prior to the delivery of the policy applied for unless and until all conditions of this receipt have been fulfilled exactly. No agent or field representative is authorized to waive or modify any of the provisions of the Conditional Receipt.

Make all checks payable to the Company. Do not make checks payable to the agent or leave the payee blank or you may jeopardize the insurance for which you have applied.

Received from _____, the sum of $_____ for the insurance application dated _____, with _____ as the proposed Insured(s). The policy you applied for will not become effective unless and until a policy contract is delivered to you and all other conditions of coverage are met. However, subject to the conditions and limitations of this Receipt, conditional insurance under the terms of the policy applied for may become effective as of the later of (1) the date of application and (2) the date of the last medical examination, tests, and other screenings required by the Company, if any (the "Effective Date"). Such conditional insurance will take effect as of the Effective Date, so long as all of the following requirements are met:

1. Each person proposed to be insured is found to have been insurable as of the Effective Date, exactly as applied for in accordance with the Company's underwriting rules and standards, without any modifications as to plan, amount, or premium rate;
2. As of the Effective Date, all statements and answers given in the application must be true;
3. The payment made with the application must not be less than the full initial premium for the mode of payment chosen in the application, must be received at our Administrative Office within the lifetime of the proposed Insured to whom the conditional coverage would apply and, if in the form of check or draft, must be honored for payment;
4. All medical examinations, tests, and other screenings required of the proposed Insured by the Company are completed and the results received at our Administrative Office within 60 days of the date the application was completed; and
5. All parts of the application, any supplemental application, questionnaires, addendum and/or amendment to the application are signed and received at our Administrative Office.

Any conditional coverage provided by this Receipt will terminate on the earliest of: (a) 60 days from the date the application was signed; (b) the date the Company either mails notice to the applicant of the rejection of the application and/or mails a refund of any amounts paid with the application; (c) when the insurance applied for goes into effect under the terms of the policy applied for; or (d) the date the Company offers to provide insurance on terms that differ from the insurance for which you have applied.

If one or more of this Receipt's conditions have not been met exactly, or if a proposed Insured dies by suicide, the Company will not be liable except to return any payment made with the application.

If the Company does not approve and accept the application for insurance within 60 days of the date you signed the application, the application will be deemed to be rejected by the Company and there will be no conditional insurance coverage. In that case, the Company's liability will be limited to returning any payment(s) you have made upon return of this Receipt to the Company.

The aggregate amount of conditional coverage provided under this Receipt, if any, and any other Conditional Receipt issued by the Company shall be limited to the lesser of the amount(s) applied for or $500,000 of life insurance. There is no conditional coverage for riders or any additional benefits, if any, for which you have applied.

Authorization (Signatures Required)
I certify that I have read and reviewed the Conditional Receipt and the acknowledgment of the applicant and proposed Insured in the application. The terms and conditions of the Conditional Receipt have been explained to me fully by the agent and I understand them.

Dated at _____ on _____ _____

City State Date Signature of Agent or Authorized Company Rep

_____ _____

Signature of proposed Insured Signature of Applicant (if other than proposed Insured)

DETACH AND LEAVE THIS PAGE WITH APPLICANT

NOTICE TO PERSONS APPLYING FOR INSURANCE
REGARDING INVESTIGATIVE REPORT

To proposed Insured: In connection with this application, an investigative consumer report may be prepared about you. Such reports are part of the process of evaluating risks for life and health insurance. Typically, this report will contain information about your character, general reputation, personal characteristics and mode of living. The information in the report may be obtained by talking with you or members of your family, business associates, financial sources, neighbors, and others you know. You may ask to be interviewed in connection with the preparation of any such report. Also, we may have the report updated if you apply for more coverage.

Upon your written request, we will let you know whether a report was prepared and we will give you the name, address, and telephone number of the agency preparing the report. By contacting that agency and providing proper identification, you may obtain a copy of the report.

MIB GROUP, INC. (MIB) PRE-NOTIFICATION

To proposed Insured: Information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report on this information to MIB Group, Inc., a non-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB may, upon request, supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill, Suite 400; Braintree, Massachusetts 02184-8734; and telephone number is 866-692-6901 (TTY 866-346-3642 for hearing impaired).

NOTICE OF INSURANCE INFORMATION PRACTICES

To proposed Insured: Personal information may be collected from persons other than the individual proposed for coverage. Such information as well as other personal or privileged information subsequently collected by us or our agent may in certain circumstances be disclosed to third parties without authorization. Upon request, you have the right to access your personal information and ask for corrections. You may obtain a complete description of our Information Practices by writing to Western Reserve Life Assurance Co. of Ohio, Attn: Director of Underwriting, [4333 Edgewood Road NE, Cedar Rapids, Iowa 52499].

PLEASE PROVIDE A COPY OF THIS NOTICE TO THE PROPOSED INSURED IF NOT A HOUSEHOLD MEMBER.

SERFF Tracking Number:	*AEGB-126762984*	*State:*	*Arkansas*
Filing Company:	*Western Reserve Life Assurance Co. of Ohio*	*State Tracking Number:*	*46492*
Company Tracking Number:	*L121 0510WAR*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*L121 0510WAR*		
Project Name/Number:	*Application For Individual Life Insurance/L121 0510WAR*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachments:

AR - Rule and Regulation 19.pdf

Flesch Score.pdf

Item Status: **Status Date:**

Satisfied - Item: Statement of Variability

Comments:

Attachment:

L121 0510W Statement of Variability.pdf

Western Reserve Life Assurance Co. of Ohio
Home Office: Cedar Rapids, Iowa

COMPLIANCE CERTIFICATION
RULE AND REGULATION 19
STATE OF ARKANSAS

Form Number: L121 0510WAR

Date: August 13, 2010

We certify that, to the best of our knowledge and belief, this submission meets the provisions of Rule and Regulation19 as well as all applicable requirements of the Insurance Division of the State of Arkansas.

Cheryl Bock, Assistant Vice President, Contract Development

WESTERN RESERVE LIFE ASSURANCE CO. OF OHIO
FLESCH READABILITY CERTIFICATION

Form Number (may vary by state)	**Flesch Score**
L121 0510W	51.3

I certify that the machine scored Flesch Readability score for the above mentioned form is accurate.

Cheryl Bock

_____

Cheryl Bock, Assistant Vice President, Contract Development

WESTERN RESERVE LIFE ASSURANCE CO. OF OHIO
STATEMENT OF VARIABILITY

APPLICATION: L121 0510W

We have bracketed the variable items in this form. No change in the variability will be made which in any way expands the scope of the wording. Western Reserve Life Assurance Co. of Ohio reserves the right to correct, at any time, any and all typographical errors that do not impact the benefits or intent of language.

L121 0510W – Application for Individual Life Insurance

1. **Mailing Address** (page 1): This may change to another location in the future.

2. **Additional Benefits** (page 1): Additional Riders the proposed Insured is apply for.

3. **Underwriting Department Address** (page 6): This may change to another location in the future.